DOCUMENT RESUME

ED 449 332 CE 081 213

AUTHOR	Wirtz, Ron
TITLE	New Wrinkle on Aging: Baby Steps to 2030. Aging Initiative Project 2030 Policy Report.
INSTITUTION	Citizens League, Minneapolis, MN.
SPONS AGENCY	Minnesota State Dept. of Human Services, St. Paul.
PUB DATE	1998-12-00
NOTE	33p.; For other Project 2030 documents, see CE 081 005.
AVAILABLE FROM	For full text: http://www.citizensleague.net/projects/2030/report.htm.
PUB TYPE	Opinion Papers (120)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Aging (Individuals); Baby Boomers; Community Change; *Community Development; *Futures (of Society); *Long Term Care; Older Adults; *Older Workers; *Public Policy; Quality of Life; Statewide Planning; Work Environment
IDENTIFIERS	*Minnesota

ABSTRACT

This policy report is intended to be a vision, a design, for certain public systems that have significant involvement with an aging population. It focuses on the central question: What can be done to build community capacity for dealing with an aging society in Minnesota? The report focuses on these three topics: (1) life-cycle communities--designing neighborhoods and cities that are sensitive to and provide for the needs and wants of all people; (2) workforce--using the various talents and abilities of older people to the mutual benefit of society and older people themselves; and (3) long-term care--providing support, care, and other services to older people to improve their quality of life. A separate section on each topic consists of these elements: the vision; current trends; consequences for failing to act; and recommended first steps. The vision element for the three topics addresses the following: what will communities look and act like in 2030? What do we want the workplace to look like in 2030? and What do we want long-term care to look like in 2030? Appendixes include a report of the work of the task force and a list of other public meetings and events. (YLB)

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ED 449 332

PROJECT AGING INITIATIVE 2030 POLICY REPORT

NEW WRINKLE ON AGING:

Baby Steps to 2030

Citizens League

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December 1998

Project 2030 is an initiative of the State of Minnesota, housed within the Minnesota Department of Human Services and carried out in partnership with the Minnesota Board on Aging. The project is identifying the impact of the aging of the baby boom generation, and preparing the state's response to the challenges posed by this change in Minnesota's age structure.

This report is one in a series of policy reports published as part of the Project 2030 initiative. The report was prepared by the Citizens League, under contract to Project 2030, through its citizen-based policy study committee process.

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PROJECT **2030**

NEW WRINKLE ON AGING:

Baby Steps to 2030

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December 1998

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Foreword

A New Wrinkle on Aging is a joint venture by the Citizens League and the Minnesota Department of Human Services (DHS), and part of DHS's *Aging Initiative: Project 2030* being carried out in partnership with the Minnesota Board on Aging.

A New Wrinkle on Aging began with a series of public forums in the spring of 1998, and culminated in the public policy report that follows.

The goal of the entire ***A New Wrinkle on Aging*** project is to heighten general public awareness and identify implications of an aging baby boom generation. The policy report that follows is an advisory report to DHS as the department prepares its own report to the new governor and the Legislature on aging issues facing the state. ***A New Wrinkle on Aging*** hopes to set in motion some initial policy steps for lawmakers, public agencies, non-profit organizations and businesses that begin addressing serious policy issues related to the wave of baby boomers journeying from middle age to old age.

This policy report was prepared by the Citizens League, which was contracted to organize and administer a citizen-based policy study that took a deliberative look at the issues, consequences and choices facing the State of Minnesota and its residents regarding the aging of its population. As such, this document is not a Board-endorsed policy report of the Citizens League, but a DHS-sponsored task force report that utilized the Citizens League study committee process.

For more information on the work of this task force, please see Appendix A on p. 25. For more information on other events and meetings that took place as part of ***A New Wrinkle on Aging***, see Appendix B on p. 29.

Introduction

Demographics paint a clear picture of Minnesota's future: a huge number of baby boomers are moving toward older age. By 2030, the number of people over the age of 65 is expected to double, from 592,000 in 2000 to 1,173,000 in 2030.[1] What's more, the number of people under the age of 65 is expected to actually *decline* slightly.

Table 1

Minnesota's Population By Age Group
2000 - 2050

Age	2000	2010	2020	2030	2040	2050
0 – 14	973,128	890,494	903,275	878,443	838,840	828,687
15 - 64	3,083,840	3,298,801	3,241,306	3,089,467	3,085,994	3,001,443
65 – 84	500,446	559,317	791,888	1,030,750	963,634	903,051
85+	91,886	112,470	118,192	142,580	210,206	250,873
TOTAL	4649,300	4,861,082	5,054,561	5,141,250	5,098,674	4,984,054
65+ TOTAL	592,332	671,787	910,080	1,173,339	1,173,840	1,153,924

Source: Minnesota Demographer's Office, 1997

Table 2

Minnesota's Older Population By Age Group
2000 - 2050

Age	2000	2010	2020	2030	2040	2050
85+	101,886	112,470	118,192	142,580	210,206	250,873
80 – 84	88,999	96,364	102,169	160,920	212,094	170,155
75 - 79	120,376	117,061	156,126	237,820	257,408	196,621
70 – 74	140,123	146,970	231,293	304,962	244,345	239,597
65 – 69	150,948	198,923	302,280	327,057	249,767	296,678
TOTAL 65+	592,332	671,788	910,060	1,173,339	1,173,820	1,153,924

Source: Minnesota Demographer's Office, 1997

Aging of the state's population is not a problem in itself, for it is a natural and reasonably predictable process. But demographic changes will threaten the function and capacity of existing government support systems at all levels in Minnesota, as many systems today are ill-equipped to deal with the expected consequences of aging.

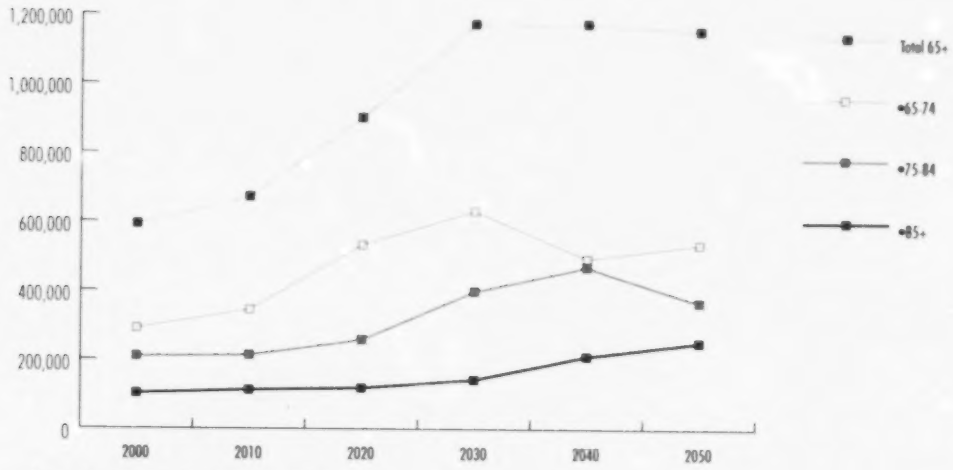
1 Aging Initiative: Project 2030, Briefing Book, 1998. This projection, and others that follow in this report, assume that current trends relating to such things as life span, migration, and fertility rates will remain relatively unchanged over time. Any change in these and other factors (e.g. finding a cure for cancer) will obviously have an impact on the demographic make-up of the state 30 years from now.

Many mistakenly see the aging of the population as one big, homogenous group. Society in 2030 will, in fact, be older, but it will be made up of many different sub-groups, each of which will have different characteristics and needs.

For example, projected growth rates will vary among different age groups of older people. The number of "young-old" (65-74) will more than double to 632,000, while the "mid-old" (75-84) will rise 90 percent to 400,000, and the number of "old-old" (85+) will increase about 40 percent to 143,000.[2] The longevity gap between men and women will narrow; the number of men over the age of 65 will almost double to 463,000, while the number of women over 65 will increase 70 percent to 578,000.[3]

Figure 1

Minnesota's Older Population by Age Group
2000-2050



Source: Minnesota Demographer's Office, 1997

In Minnesota, the general population of older people also will become more racially diverse, but remain a largely white population. The non-white population of older people is expected to quadruple but still reach only 50,000 by 2030 — less than 5 percent of the state's elderly population.[4]

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2 Briefing Book, 1998.

3 State Demographic Center, Faces of the Future: Minnesota County Population Projections 1995-2025, Minnesota Planning, September 1998.

4 Faces of the Future, 1998.

Most geographic areas of the state will experience growth in people over 65 in the coming decades. The majority, however, will be concentrated in the Twin Cities region and the "collar" counties immediately adjacent to the north.[5] Seventeen counties — most of them in the southwest — will see stagnant or declining numbers of older people. The remaining counties will see a varying rate of growth, with many of the higher growth counties in Greater Minnesota within commuting distance of a larger metropolitan city.[6]

Adapting current systems to these shifting demographics is complicated by the fact that the biological process of aging and the social setting in which it occurs is changing dramatically — the result of technology, medical breakthroughs, increasing cultural diversity, and a new information-based economy, to name but a few factors.

In 1970, people at the age of 65, 85, even 100, faced significantly different aging effects and circumstances than they do today. We can assume the same will hold true in 2030 compared with today, although it is hard to predict exactly how and to what extent today's systems and circumstances will change by 2030.

The rapid pace of technological and medical advance, for example, will have a profound but unknown impact on society over the next 30 years. Virtual, in-home medical and social support visits might be commonplace in 2030; a cure for cancer, Alzheimer's or even arthritis would change society in ways we would not likely imagine.

Within the limited boundaries of forecasting, however, we can expect that by 2030 age and the aging process will be measured less by *chronology* — how old you are — and more by *chronicity* — the prevalence and intensity of various chronic conditions and a person's general functional ability (or lack thereof).

We can also expect that an aging population will bring many social changes as well. For instance, boomers will hold significant political power as they age, due to the sheer size of the boomer cohort group and the typical voting habits of older people. Today about one in eight people are over the age of 65; by 2030, that ratio will almost double to about one in four.[7]

Boomers nationwide also are in line to receive literally trillions of dollars in inheritance from their parents. Combined with higher average life-time earnings and a penchant for spending, boomers will possess greater market power for goods and services in their older years than any previous generation of older people.

This power base will likely have a profound — if currently unpredictable — effect on the way society thinks about many topics, including the issue of aging itself and the role of older people in our society.

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5 The population over 65 in each of the metro's suburban and "collar" counties is expected to rise between 100 percent and 350 percent. Similarly, the growth rate in people over 65 in Hennepin and Ramsey is lower (both in the 50-100 percent range), but due to their larger populations, the growth in numbers will be significant.

6 *Faces of the Future*, 1998.

7 Aging Initiative: Project 2030, *Briefing Book*, 1998.

However, not all boomers will benefit from this new-found power. For one, greater disparities are expected in the future between the "Boomer-Haves" and the "Boomer-Have-Nots." While more boomers are expected to reach upper-income status in the future, more are expected to be living in poverty as well.[8]

Given these many factors, the most significant and necessary change for our institutions — government, business and non-profits — will be a shift away from paternalistic systems that traditionally see older people as dependents, and toward new systems that promote *inter*dependence and *in*dependence, and help older people maintain productive, fulfilling lives.

Because of the slow-moving nature of systems, change must begin immediately. This task force has been organized to provide thoughtful, reasoned deliberations that identify the necessary policy steps to initiate such change.

This report is intended to be a vision, a design, for certain public systems that have significant involvement with an aging population. It focuses on the central question: *What can be done to build community capacity for dealing with an aging society in Minnesota?*

Due to the allotted length of this study, and the number and complexity of issues, this report focuses on three topics:

- ***Life-cycle[9] communities*** — designing neighborhoods and cities that are sensitive to, and provide for the needs and wants of, all people;

- ***Workforce*** — utilizing the various talents and abilities of older people to the mutual benefit of society and older people themselves;

- ***Long-term care*** — providing support, care and other services to older people in order to improve their quality of life.

Minnesota communities find themselves with a unique opportunity. While addressing very serious, potentially intractable problems related to the aging of baby boomers, communities have the coinciding opportunity to significantly improve the lives of older people.

The intent of this report is not to simply tinker around the margins of the existing systems, but rather to *create a vision for new systems* by the year 2030 that improves the quality of life of older people, and to identify the steps necessary to move toward this vision.

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8 American Association of Retired Persons, *Boomers Approaching Midlife: How Secure a Future?* Public Policy Institute, 1998.

9 The term "life-cycle" refers to the changing needs of a person over the course of his or her lifespan. In this sense, "life-cycle" communities provides elements that people of all ages need through different stages of life.

A New Wrinkle on...

Life-Cycle Communities

VISION 2030: WHAT WILL COMMUNITIES LOOK AND ACT LIKE IN 2030?

1. ***More Minnesota communities in 2030 will be truly livable for all age groups; they will be transgenerational and life-cycle in nature, offering diverse choices that provide for the future needs of all residents including older people.***

More than at any other level, local communities will hold the key to improving the lives of older people and creating livable environments for all people. Communities that are truly age-sensitive and age-inclusive will stress *access* and *choice* for basic things needed by all people in every community: housing, healthcare, life-long learning opportunities, recreation, jobs and daily goods and services. In particular, communities in 2030 will promote a wide range of housing styles and options that offer older persons real choice for dependent or independent living.

Because of the changing nature of Minnesota communities — most are not only aging, but becoming more racially and culturally diverse as well — community planning will increasingly be viewed through the "kaleidoscope of diversity" in an effort to recognize the many different needs and services within an individual community.

2. ***Communities in 2030 will support the ability of older people to live independently longer.***

Formal and informal support networks in communities will provide diverse, in-home services that allow older persons to retain their independence longer. By 2030, technology advancements and innovative design features will help mitigate in-home physical limitations common today. New delivery mechanisms — including the Internet, and service bundling from different providers — will increasingly bring goods and services to people's homes.

Communities in 2030 will also offer their residents convenient access to services and amenities outside of their home. Transportation options will be expanded that make it easy and convenient for older people to access goods, services and social needs on their own. Communities in 2030 will place goods and services in closer geographic proximity to older persons, eliminating or reducing the need for travel to receive goods and services.

3. ***Communities in 2030 will offer a wide array of volunteer and social interaction opportunities for all community residents including seniors, which will help build the personal and social relationships necessary to create support networks for people of all needs and abilities.***

Despite technological advances that improve people's care and access to goods and services, people-to-people relationships will still be critical, and communities will harbor the responsibility for nurturing personal relationships that make life fulfilling.

For example, to enhance the physical and mental health of older people, community-based organizations — local government, non-profits, businesses, schools, social and volunteer clubs — will provide meaningful opportunities for political, social, and recreational involvement for all residents.

In particular, communities will look to older people as the key link in organizing and operating activities for many different age groups, including their own. This will help keep older people active and productive, and help build informal relationships necessary for a community to meet the many needs of its residents.

CURRENT TRENDS

- Current development models for housing are targeted to those with resources; those without resources often have few housing options, particularly in Greater Minnesota.
- Throughout the state, new development predominantly follows a suburban model — large-lot, single-use, auto-oriented — even in Greater Minnesota and in urban areas being redeveloped.
- There is interest in building more compact, integrated, mixed-use living environments, but much slower implementation of these land-use concepts. Local zoning ordinances often prevent development from deviating from the status quo.
- Local communities are reacting to (and not actively planning for) an aging populace. Many communities still think in terms of immediate needs of particular market segments (like more "single-family residential" or "senior housing") instead of planning for both the short-term and long-term life-cycle needs of their particular community.
- While there have been small-scale demonstrations and some investment in non-auto, multi-modal transportation options, there is little foreseeable change in general travel patterns and general accessibility. Mobility and accessibility will continue to be auto-oriented, particularly in suburban and rural parts of the state.

- Social services within many communities are often fragmented and uncoordinated, sometimes in spite of (or perhaps because of) the presence of a multitude of providers. In other cases, particularly in rural Minnesota, there is a dearth of service options and providers for older people.

- In communities statewide (and nationwide), there has been a steady decrease in participation in most traditional social service clubs, like Rotary, Kiwanis, Lion's, League of Women Voters, etc. Informal relationship networks are increasingly strained (or never made) within communities when young people move away to find jobs, when families are split through divorce, when increased diversity is met with suspicion and fret, and when older people are viewed as community liabilities rather than assets.

CONSEQUENCES FOR FAILING TO ACT NOW

- An increasing number of people will be geographically isolated from health and social support services due to auto-dominated accessibility, poor transportation alternatives and poorly-fitted service delivery mechanisms. Depending on technological advancements, such people might either not receive needed health and social services while in their homes, or be in jeopardy of premature institutionalization.

- The state's current affordable housing crisis will be magnified significantly when boomers begin looking for housing options outside the single-family housing market.

- The Twin Cities region will experience geographic concentration and on-going intensification of poor older people in the central cities and first ring suburbs, where the majority of affordable and subsidized housing currently exists. With a severe scarcity of affordable housing, older people in Greater Minnesota who are unable to continue living in their homes will have few housing options, which could lead to greater homelessness and reliance on family and friends for housing.

- For those older people able to drive, the number and length of automobile trips will continue to increase because they are geographically separated from people and necessary services within communities.

RECOMMENDED FIRST STEPS

1. ***The Department of Housing Finance, Minnesota Planning, other state agencies, for-profit and non-profit building industries, housing associations and housing advocates must work diligently with local municipalities on reworking zoning ordinances and other land use regulations that generate persistent low-density, single-use, auto-oriented development. In its place, municipalities should move toward a flexible land-use pattern that integrates different uses, housing types, and income levels. Specifically:***

   a. All municipalities must address zoning ordinances and other land use regulations that preclude the development of compact, mixed-use development. Cities must also address regulations that prevent the private market from developing affordable housing options for older people, and the Legislature must address similar disincentives in property tax laws.

   b. The Department of Housing Finance and DHS should partner with the Metropolitan Council's Livable Communities Demonstration Account and the Greater Minnesota Housing Fund to run a larger number of small-scale demonstrations of innovative design projects.

      Stakeholder groups also need to find ways to streamline and "scale-up" the replication of successful test projects in order to have a real impact on housing problems throughout the state. Such demonstrations are particularly critical in Greater Minnesota, where there is a dearth of choice in housing for older people. Specifically, demonstrations should test:

      - affordable, market-rate options for assisted, congregate and other living arrangements for older people, including investigation of new rental and ownership choices.

      - the usefulness of mixed-income housing and mixed-use housing (residential commingled with commercial uses), as well as accessory housing units to single-family housing that promote living arrangements conducive to informal care.

      - access-friendly design for older persons (both internal housing design and a community's physical design).

      - transit redesign — particularly in rural and suburban areas where there are few transit options for adults; for example, redesigning and "bundling" public transportation to serve schools and the larger community simultaneously.

      - public-private partnerships that spur investment and innovative access and choices for housing, transportation and service delivery.

c. DHS, Minnesota Planning and the Metropolitan Council must engage growing communities during their comprehensive planning process (currently underway in the metro area and in some communities in Greater Minnesota) on the need to understand and consciously plan for the needs and abilities of older persons in the community, both today and in the future. Incentives — possibly in the form of community block grants — should be available for those cities that plan proactively for the needs and demands of older people.

Specifically, communities should examine and plan their role in providing access to advanced technologies of 2030 — particularly those technologies that improve people's access to information and services, and by relation, their ability to care for themselves and live independently.

Similar to the planning that took place around community libraries this century, future planning will demand that communities rethink the concept of information access, understand the capabilities of and demand for new technology, and design a delivery mechanism well-fitted to serve the information and service needs of the community and its residents.

A New Wrinkle on...

Workforce

VISION 2030: WHAT DO WE WANT THE WORKPLACE TO LOOK LIKE IN 2030?

1. ***In 2030, "work" will not be limited by age, but by hard and soft skills and individual motivation.***

In general, the workplace of 2030 maximizes the skills of all people interested in entering or remaining in the workforce. The global, knowledge-based economy will place a premium on high-order cognitive skills, and the forecasted labor shortage will bring added value to all workers. The workplace of 2030 will have challenged the myth that older workers are universally less productive, and employers will recognize the value of skills that experienced people bring to the workplace. Equity in pay and position will be realized in the workplace by 2030.

Employers in 2030 will seek out older workers at two different levels. On one level, older workers will be desired (or at least considered qualified) for high-skill positions due to their life-long work experience in the private, public and independent sectors. At another level, employers with lower-skill, low-stress jobs will cater to older people interested in work for income stability as well as social and self-fulfillment purposes. As a result, the percentage of older workers in part-time, seasonal, temporary and consultative positions will rise dramatically.

2. ***The workplace of 2030 will follow a new, redefined concept of retirement not determined by an arbitrarily designated age, but by mental and physical capacity and personal financial preparation.***

Retirement in 2030 will have been redefined and in many ways removed from the lexicon altogether. "Retirement" in the new sense will be determined by a person's functional ability, personal motivation and financial preparation to support her or himself without employment income.

By 2030, older people will depend less on Social Security due to the steady erosion of its purchasing power, higher lifestyle expectations, and longer life spans of older people. As a result, people will use Social Security to supplement other income earned from such things as employment, investments, and pensions.

Work that is traditionally undervalued — informal caregiving, homemaking, volunteering — will be credited or somehow compensated to balance the discrepancy of wage-earning versus non-wage earning work, and to provide older people with additional avenues for supplementing their income and meeting basic needs.

3. *The workplace of 2030 will be notable for its flexibility and ready access to training and life-long learning; as such, traditional retirement will give way to new stages of personal and career development.*

Unlike the structured workplaces of the past, with 8-to-5 routines, the rule of thumb in the workplace of 2030 is flexibility and productivity, due in part to a prolonged labor shortage in the state.[10] This will create better access to the workplace and more rewarding work opportunities for older workers if they choose to stay employed. The workplace in 2030 will be less traditionally structured and place-based, focusing instead on the means necessary to continually improve productivity. For instance, technology will make it easier to work at home, which will expand job opportunities for older people.

The push for improved productivity, coupled with a lack of workers, will increase both the public and private sectors' interest and willingness to invest in new skills for older workers. The public sector will help fill training gaps for older workers not provided by the private sector. Such training will upgrade and update the skills of older workers, giving them greater opportunities to pursue new (if possibly less intense) careers in their "second adulthood."

CURRENT TRENDS

- Despite significant increases in women's participation in the workforce, women are still much less likely to have pension or other employment-based retirement income. Those women who have employment-based retirement income often receive significantly less than their male counterparts because women traditionally have been in lower-paid jobs and often take time out to raise children and attend to other necessary care-giving demands (particularly aging parents).

- A number of existing laws and social programs, such as Social Security, discourage work beyond a certain age — a situation that is changing, but slowly, evident in the increase in the age eligibility of Social Security.

- Without Social Security, fully half of all people over the age of 65 would be living in poverty.

- The state and nation are currently on the front-end of a significant labor shortage that is predicted to last several decades.

- Seniors are living longer, and living *healthier* longer, creating an increasing span between retirement and death.

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10 See Citizens League, *Help Wanted: More Opportunities Than People*, November 1998.

- The economy has shifted from an industrial/manufacturing base to information and service base, with a related decrease in physical-labor types of jobs and an increase in the number of part-time, seasonal, temporary and other "just in time" jobs.

- While employers' attitudes toward older workers are changing for the better (largely the result of the current and future labor shortage), age-bias is still evident in the workplace.

- People with means are retiring earlier from their "career jobs." Some continue in a lesser capacity in their career fields, others pursue "secondary careers" in an unrelated field of interest, and still others leave the workforce altogether.

CONSEQUENCES FOR FAILING TO ACT NOW

- There will be a significant increase in the dependency ratio of older people if boomers leave the workforce at "traditional" retirement age. This will create serious financial consequences for the state, as the pool of tax-paying workers grows much more slowly than the pool of non-working older people receiving publicly-financed benefits.

- A severe labor shortage, caused by lack of replacement workers for boomers as they leave the workforce, could cause many businesses to fail or relocate, particularly those that are not able to find substitutes for human labor.

- Inflationary pressure could result as the current and future labor shortage creates a possible shortage of available goods and services. This inflationary pressure in turn could undermine the asset and income wealth of retirees who planned financially (if at all) for different economic conditions.

- People depending on Social Security as their sole or even main source of income will likely live in dire poverty.

RECOMMENDED FIRST STEPS

1. ***DHS and the Legislature should lobby Congress to revise eligibility for Social Security, creating new standards based on mental and physical capacity and financial criteria.***

2. ***The State Legislature, with assistance from the state departments of Human Services, Economic Security, Labor and Industry, Finance, and Revenue, must link income policy more closely with labor policy.***

   Individuals must be employed or otherwise earning income in order to prepare financially for their retirement. For this reason, state policy regarding such labor-related

issues such as economic development and workforce training must be congruent with income-related policies like taxation and entitlement benefits. One example of failed linkage (albeit, at the federal level) is the penalty older people pay on Social Security benefits if they continue to work. The Legislature could eliminate that work disincentive through a tax credit recouping an older worker's lost Social Security benefits.

3. ***Overcome barriers to greater participation of older people in the workforce, particularly for part-time, temporary, seasonal and consultative positions — staples in the work lives of older people in 2030.***

   a. The state and business community, should lobby the federal government to make pensions and healthcare coverage more widely available and portable. Such changes would provide incentives to older workers interested in staying in the workforce.

      Another healthcare coverage option is for the state to create a reinsurance pool that gives businesses access to affordable health insurance for seasonal, part-time, temporary and consulting positions that traditionally offer few benefits and no health coverage.

   b. Much as it did in offering healthcare benefits, businesses should pool workers and available resources to offer open access to long-term care insurance (LTCI) as a standard workplace benefit. This is already occurring as a workplace benefit to an extent, and needs to be accelerated. Open access can be achieved through different measures, including employer-paid LTCI, or an employer-organized group policy that offers employee and family buy-in options.

   c. Investigate and support the establishment of "senior industries" that takes advantage of the skills of older workers, and promote economic development that taps into this under-utilized labor pool. One option would be for the Department of Trade and Economic Development to include senior-related businesses (products and services both for and by older people) in its "industry-specific" assistance program (which currently includes computers/electronic components, healthcare/medical care products, printing/publishing, tourism, and wood products/plastics/composites).

4. ***Municipalities, with the assistance of the Department of Economic Security and Workforce Centers throughout the state, should link traditional senior services and programming at the local level with job and volunteer information resources and referral services.***

5. ***New efforts must be taken to recognize, encourage and reward productivity in all its forms, whether paid or unpaid. For example:***

   a. Volunteer programs should offer some tangible rewards and incentives to volunteers that would also serve larger purposes. For instance, programs should be established in both private and non-profit organizations that provide long-term care insurance as an

inducement to participate in volunteer activities, as well as an inducement to have long-term care coverage. Group plans make long-term care insurance affordable (through economies of scale) and easy to establish and administer.

b. State licensing boards should waive the licensing fees for people who want to continue practicing their profession in a volunteer capacity, while maintaining the standards and criteria necessary for licensure.

c. The State Legislature should review and clarify current volunteer indemnity laws that shield some volunteers from liability while serving as care providers and other valuable positions. An update of our no-fault auto insurance system, particularly the threshold for liability, should be revisited in view of nearly 25 years of healthcare cost escalation. The legislative objective of each of these measures is to provide non-profit organizations with better leverage in recruiting and involving older people in volunteer activities.

A New Wrinkle on...

Long-Term Care

VISION 2030: WHAT DO WE WANT LONG-TERM CARE TO LOOK LIKE IN 2030?

1. ***Long-term care in 2030 will have shifted toward "functional wellness" and improved quality of life for dependent persons — in essence, into a long-term support system.***

People today equate long-term care with nursing homes and frail elderly unable to care for themselves. In the future, long-term care will be broadened to deal with the many stages of aging for all older adults, while re-regulated nursing homes will instead fill "care niches" including some short-term rehabilitative care and "end of life" stays.

Long-term care in 2030 will stress "functional wellness," or *the promotion and management of physical and mental health* among older persons, striving to provide older persons with a high quality of life. The shift toward functional wellness will change the underlying philosophy of long-term care into one of long-term *support*. Recognizing that older people need more than medical care, new mechanisms will have been designed by 2030 to provide older people with necessary support services that help them to live happy, self-fulfilling, independent lives.

2. ***By 2030, people will be empowered to take responsibility for their own "self-care," having greater choice and access to a menu of flexible, individually-controlled services, rather than the fixed, placed-based service system common today.***

As people live healthier longer, so too will they be expected and enabled to care for themselves. Older people will have access to a greater range of social and medical services that will support them (and their informal care providers) in efforts to live independently.

The combination of new technology, expanded care options, financing structures and delivery mechanisms will create a broader, more flexible support system with greater choice in the types of services available and the places where these services are delivered. Such flexibility will enable long-term support in 2030 to be truly "customer-driven," allowing older people to select and control the services they need, want, and can afford.

For this to happen, long-term support will integrate different care models and expand it to a community-based "functional wellness continuum" that also incorporates social support

services. Today, the health care continuum is dissected into multiple pieces which operate largely independent of each other despite their obvious relationship to one another. As such, fundamental care practices have little integration among them.

In 2030, these currently disparate but fundamentally similar care models (along with their many different providers) will be joined and restructured into a "wellness continuum" that also offers social support services to assist older people in their everyday living — all of which will be delivered at the community level.

3. ***Changes in how society views death and related "end of life" issues by the year 2030 will be embodied in the newly designed long-term support system, whereby public resources will be used to*** **enhance the quality** ***of life of older people rather than focusing almost exclusively on*** **extending** ***life.***

Today's care systems are influenced heavily by society's general fear of death. By 2030, society's perceptions of death and care will have evolved to be more accepting and respectful of death. By 2030, the Minnesota community will have come to a consensus — politically, religiously, and culturally — about "end of life" caregiving issues, and established priorities for available resources that maximize people's quality of life.

As a result, by 2030, public resources will be shifted increasingly to the "front end" of the health equation for older people — to illness prevention and health maintenance, and the support of a high quality of life for older people, instead of on acute episodic care and the short-term extension of life at or near the natural end of one's life.

4. ***In 2030, older people will have guaranteed access to universal, "buy-in" coverage for long-term support based on income.***

Today, real choice for long-term support services today is very limited, and stands in marked contrast to the universal coverage older people receive for acute care under Medicare. But by 2030, the state will offer universal access to long-term support services aimed at helping older people live independently.

Universality will be affordably achieved through a "buy-in" program that will charge older people premiums based on their income. Each recipient will then receive a core package of long-term support services, while the private market will be left to provide "gap" insurance for additional services beyond this core package, thereby expanding choice for private payers.

5. *Long-term support in 2030 will have evolved to meet the many different needs to a diverse population.*

Increased diversity in the state in the coming decades brings with it the need to rethink existing care and support systems and make them more accessible and user-friendly for people with different needs and expectations. By 2030, the long-term support system will be sensitive and better tuned to cultural differences in care and support needs of different populations. Providers will compete for customers based on their ability to appropriately customize these services.

CURRENT TRENDS

- Increasingly, there is disruption or absence of informal care networks due to smaller families, higher divorce rates, and greater geographic dispersion. This will continue to be true particularly in rural Minnesota, where children often move away to look for jobs in metro areas.

- The long-term care industry is slowly evolving in Minnesota. Nursing homes are gradually moving into rehabilitative care and "end of life" stays. New housing and service options for older people, such as assisted living, are being developed, but slowly and primarily for people with means. The state is also slowly expanding programs for community- and home-based care programs covered under Medical Assistance.

- There is a lack of choice in care services in Greater Minnesota, including but not limited to long-term care. Compounding and contributing to this lack of service is a shortage of workers in nursing homes and other long-term care organizations that struggle to attract workers for comparatively low paying jobs.

- The existing long-term care system is still geared mainly toward whites, with little adaptability or sensitivity to the needs of older people from different cultures and races.

- The influence and presence of managed care will increase in the long-term care industry, particularly in light of the fast-growing population of older people, who consume a disproportionate share of all health-related services.

- The use of technology will increase dramatically throughout different care systems, but particularly in long-term care, where it has yet to have a large influence.

- While the *rate* of disability has been decreasing, the overall *number* of disabled people is growing and will continue to increase due to the sheer size of the older population in the coming decades. As age longevity increases, so too will incidence of chronic conditions.

- Many baby boomers refuse to believe that they will need assistance of some form as they age (despite research to the contrary), and few have made any concrete financial plans relating to long-term care.

CONSEQUENCES FOR FAILING TO ACT NOW

- The current configuration of healthcare financing will bankrupt the state if no changes are made. Costs will continue to spiral upwards as huge numbers of boomers enter a long-term care system that is very institutionally-oriented and expensive compared with community- and home-based care. At the national level, Medicare spending will consume an ever-growing portion of the federal budget as it provides universal healthcare coverage for older people for a growing number of years for the average recipient. Managed care alone is unlikely to control costs.

- Many rural areas of Minnesota will see already-poor service availability cut even further as populations continue to decline, costs increase, and private businesses and other providers struggle to find workers for acute and supportive care positions.

- Without changes in the predominantly acute-care approach to treating many chronic conditions, related medical costs will spiral upward as the older population grows, consuming an ever-greater portion of healthcare expenditures for little real improvement in older people's quality of life.

- Despite the modest assistance needs of many older people, the number of individuals relying on the state for long-term care will increase dramatically because few other support options are available, especially for people of modest means.

- Without changes in mission, staffing requirements, wages, or care levels, labor-intensive long-term care organizations will reduce capacity, relocate or close for lack of staffing.

RECOMMENDED FIRST STEPS

1. ***The state Legislature and DHS, in partnership with healthcare providers, should lobby Congress to experiment with a significant shift in Medicare spending toward preventive care and self-care, and away from acute episodic care; similarly, the state Legislature and DHS should lobby Congress for additional Medicaid waivers that allow the state to continue expanding non-medical long-term support services (i.e., mental health and chore services) that are matched by federal dollars.***

2. ***DHS should use small- and large-scale demonstrations to start or continue testing delivery mechanisms that give participants choice in care provider and in specific long-term support services offered. Demonstrations should be partially or fully funded by the Department of Human Services and interested counties, but run by providers. Demonstrations should test:***

a. inclusion of and funding for long-term support services (such as "chore" and mental health services), as well as community-based programs (like the Block Nurse Program, Senior Companion and Living-at-Home) as part of the covered service package in long-term care programs.

b. preventive measures that reduce the incidence of and necessity for acute care treatment for chronic conditions and illnesses among older persons.

c. managed care models for long-term care that pool risk appropriately with medical/acute care benefits, and also capitate and better forecast the state's short- and long-term financial commitments.

d. the role and capacity of technology in promoting self-care and home-based long-term support.

3. ***DHS, the state Health Department and Area Agencies on Aging (among others) should explore ways to compress the overwhelming scope and complexity of service options and organizations that older people must wade through when seeking care and/or support services. For example, some states are exploring the use of an "N11" calling system (e.g., 411, or 211) that provides "one-stop shopping" for care and support services. In general, such an organizing framework should:***

   a. allow older persons simplified and streamlined access to the wide range of care and support options available

   b. provide older persons with necessary information needed to make self-care decisions

   c. provide access to consumer advocates that advise older people on the services and organizations that best fit their needs and financial capacity.

4. ***The Legislature should rationalize the regulatory framework of the health care and long-term care systems now in place, clarifying and simplifying payment streams and making service delivery more flexible. For example, the Legislature should re-regulate the nursing home industry with a focus on*** **care outcomes,** ***providing the industry with flexible licensing, and creating a low-interest revolving loan program that gives nursing homes access to capital to pursue alternate care niches in an evolving market.***

5. ***The Legislature should investigate the State of Oregon's model for "end-of-life" caregiving, and begin customizing (in law) such a model for Minnesota, paying particular attention to include strong patient rights and medical self-directives.***

   Similarly, the larger Minnesota public must be actively engaged in discussing and formulating policy positions on complex "end of life" issues (such as appropriate intensity of medical treatment and quality of life) so the state and health community are not faced with reactive responses when faced with crisis situations.

Education, research and public debate are critical to such sensitive policy issues, and leadership is needed from advocacy groups (e.g., Senior Federation and the Minnesota chapter of the American Association of Retired People), research and service organizations (DHS, Area Agencies on Aging, the University of Minnesota's Center on Aging and the Center for Biomedical Ethics, the Minnesota Coalition on Death Education), as well as formal and informal groups in the faith community, social clubs, and the like.

6. ***The Department of Health should analyze the costs of chronic care, and do a "best practices" study regarding the treatment of different types of chronic care, particularly non-fatal chronic conditions, and their related costs. The goal should be to improve the long- and short-term quality of life of those suffering from chronic conditions, and to do so in a cost-efficient way.***

7. ***DHS should advocate for and track public policies including taxes that encourage long-term self-sufficiency and well-being.***

8. ***DHS and the Department of Health should help fund:***

   a. "self-care" education and training programs for older persons and informal caregivers that support continued independent living of older people at the local level and prepare them for future periods of necessary interdependency.

   b. a public education and awareness campaign to redefine and reposition "long-term care" into "long-term support."

   a. a public education campaign for better financial planning, including early planning for long-term care and support.

9. ***Long-term care organizations and their industry associations, aided by DHS, the Department of Health, and Area Agencies on Aging (among others), should make a concerted effort to recruit, educate and train more people from a variety of cultures and races to better serve the individual needs of a diversifying aging population.***

A New Wrinkle on Aging: Appendix A

Work of the Task Force

BACKGROUND FOR STUDY

The intent of this policy study is to provide a non-partisan advisory report to the Minnesota Department of Human Services (DHS) regarding the policy implications of an aging baby boom generation. The study is part of the cooperative initiative "A New Wrinkle on Aging" organized between the Citizens League and DHS, and particularly DHS' "Project 2030" which is being carried out in partnership with the Minnesota Board on Aging.

Demographics paint a very clear picture of Minnesota's future: a huge number of baby boomers are headed toward old age, and the state's current systems — its physical and social infrastructure, long-term care, workforce development systems and others — are ill-equipped to deal with some of the expected consequences.

Because of the slow-moving nature of systems, change must begin soon if the state hopes to have more effective systems in place in the future to handle and provide for the huge number of baby boomers moving into older age.

TASK FORCE ASSIGNMENT

This task force has been organized to provide thoughtful, reasoned deliberations that identify the necessary policy steps this systems change will require.

The resulting report should investigate a new paradigm for the state and its aging population: how we should design our cities and support mechanisms for an aging population; how we should deliver long-term care and other services desired by older people; and how we should utilize the various talents and abilities of older people to the mutual benefit of society and older people themselves.

In short, this report should be a vision, a design, for public systems that effectively deal with and provide service to an aging population.

This report should answer the central question:

What can the state do to build community capacity to deal with an aging society in Minnesota? What will be the roles of the public, private and non-profit sectors in this future?

Other questions to be answered by this task force, include:

- Using the topics of infrastructure (social and physical), long-term care and workforce as guideposts for system restructuring, what state actions would enable and encourage system reform?

- Aging presents different consequences for Greater Minnesota and the Twin Cities metro region. What strategies will be effective for each in building the necessary capacity to deal with aging issues?

- What are the implications for failing to act now? What initial policy steps should be considered to begin the slow process of systems change?

This study should not simply tinker with the existing systems of long-term care, infrastructure, and workforce development. Rather, it should create a vision for how these systems should look and operate, what outcomes should be expected, and what improvements they would provide over existing systems and delivery mechanisms. Lastly, this study should provide insight on the steps necessary to move current systems toward this new vision.

TASK FORCE MEMBERSHIP

Membership to the task force was solicited at the Citizens League's "Mind-Opener" breakfast series held in April (see Appendix B). An open invitation was made to attendees, and applications were sent to those expressing interest in the task force. Additional members were solicited to expand the size of the task force.

The New Wrinkle on Aging Task Force was co-chaired by Kent Eklund and Katie White. A total of 27 individuals took an active part in the work of the committee. In addition to the chairs, they were:

Anne Barry
Veronica Bennett
R. Jane Brown
Rick Carter
Dick Conner
Patti Cullen
Bonnie Esposito
Lou Fuller
Jean Greener
Katherine Hadley
John Hagman
Tom Hubler
Shirley Hunt Alexander
Jan Imsland
Beverly Kontola
Joan Lynch
Ann Meissner
Lila Moberg
Bob Nethercut
Mary Jean Overund
Bob Provost
Jim Scheu
John Selstad
Melenie Soucheray
Peter Wyckoff

MEETINGS & RESOURCE TESTIMONY

The task force met for the first time on June 10, 1998 and concluded its deliberations on October 14, 1998. The full committee met 13 times, studied a large and varied amount of printed materials, and heard from the following resource speakers:

Pat Conley, intergovernmental services manager — Assoc. of Minnesota Counties

Gail Dorfman, mayor — St. Louis Park, MN

Dr. Paul Johnson, clinical neuro psychologist

Earl Joseph, president — Minnesota Futurists

Gayle Kvenvold, president — Minnesota Health and Housing Alliance

Andrea Skolkin, executive director — Metro Area Agency on Aging

In addition, several committee members also acted as resource guests and shared their expertise with the committee, including:

Rick Carter, president — Care Providers of Minnesota

Lou Fuller, director — Office of Minority Health, Minnesota Department of Health

Jean Greener, executive director — Senior Resources

Jon Selstad, senior vice president — National Chronic Care Consortium

MEETING SPACE

Meeting space for the committee was generously donated by Minnesota Hospital and Healthcare Partnership. The League greatly appreciates such in-kind contributions to its study committees.

STAFFING

This report was prepared by Ron Wirtz. Research and other committee tasks were performed by Kris Lyndon. Trudy Koroschetz provided administrative support.

A New Wrinkle on Aging: Appendix B

Other Public Meetings and Events

As part of ***A New Wrinkle on Aging***, the Citizens League and DHS held a breakfast series forum, a policy luncheon, and a one-day symposium.

MIND-OPENER BREAKFAST SERIES

This four-week series, held at the University Club in St. Paul, drew between 80 and 100 people per event, and included the following speakers:

March 31, 1998 – Maria Gomez, Assistant Commissioner, Aging Initiative: Project 2030, MN Dept. of Human Services

April 7, 1998 – Dr. Robert Kane, director, Center on Aging, University of MN

April 14, 1998 – Dan Lindh, president and CEO, Presbyterian Homes of Minnesota, Inc.

April 21, 1998 – Michele Fedderly, senior consultant, Quantum Performance Group

MAY 19 LUNCHEON MEETING

This event, held at the Sheraton Metrodome, was attended by about 90 people.

Marilyn Moon, senior fellow Health Policy Center, Urban Institute

JUNE 17 SYMPOSIUM

This half-day symposium was held at the Radisson South Hotel, and featured:

Tim Penny, senior fellow Humphrey Institute of Public Affairs — University of Minnesota

David Durenberger, partner Durenberger Foote Public Policy Partners, LLC

Three break-out discussion sessions were organized to gain input on issues pertaining to life-cycle communities, workforce and long-term care. Summaries of the symposium can be found on the Citizens League's website at [www.citizensleague.net]. Speakers included:

Shirley Barnes, CEO — Crest View Lutheran Home

Duane Benson, executive director — Minnesota Business Partnership

Bob Bonine, financial planner — Northwestern Mutual Life

Steve Brodersen, president — Superior Senior Services

Jane Brown, commissioner — Minnesota Department of Economic Security

Charlotte Carlson, director of actuarial — Blue Cross Blue Shield of Minnesota

Karen Christofferson, public policy director — Builders Association of the Twin Cities

Dr. Leslie Grant, assistant professor, Department of Healthcare Management — Carlson School of Management, University of Minnesota

Laurel Illston, special projects coordinator — Minnesota Health and Housing Alliance

Dr. Rosalie Kane, professor — Division of Health Services Policy and Research, School of Public Health, University of Minnesota

Jim Solem, regional administrator — Metropolitan Council

Hazel Reinhardt, strategic business consultant

Moderators for the event included:

Patsy Riley, vice president of government programs, policy, and planning — Medica Health Plans, Allina Health System

George Latimer, distinguished visiting professor of urban studies — Macalester College

Kent Eklund, CEO — Cincinnatus

Additional financial support for these events was provided by:

Allina Foundation
Halleland Lewis Nilan Sipkins & Johnson
Medtronic, Inc.
Metropolitan Area Agency on Aging
St.Jude Medical, Inc.

In-kind support was provided by:

Center on Aging, University of Minnesota
Senior Health Policy Fellowship Program, University of St. Thomas.

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